

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Junior Paul Arbogast						Month Day Year			10:15 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
male	white	Aug. 5, 1932	55 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year			1:14 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY		
West Va.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		GARRETT			SAW-MILL		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)					
Oakland			(DOA) Garrett Co. Mem. Hosp.			LABORER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
W. Va.			Preston			Aurora			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
First Middle Last			First Middle Last			Route # 1					
Eberrry Arbogast			Myrtle Mick								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			218-34-2508			Bessie Arbogast			Aurora, W. Va.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										MINUTES	
IMMEDIATE CAUSE (a)										INTRACRANIAL HEMORRHAGE	
DUE TO, OR AS A CONSEQUENCE OF										CONTUSION OF BRAIN	
(b)										MINUTES	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
9123											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
CAUSE OF DEATH				10:10 AM 5-15-68				Struck in head by belt on saw-mill			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
Saw-mill				(Rural) Rowlesburg				Preston W. Va.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				5-15-68			
James H. Feaster, Jr., M. D.				DEPUTY MEDICAL EXAMINER				Oakland, Garr., Md.			
ADDRESS				23a. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Thomas, W. Va.				Rose Hill Cem.				Thomas, Tucker, W. Va.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Thomas, W. Va.				DATE MAY 20 1968				Charles Judge			

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02000

Director  
Miss A. E. Smith  
San Francisco

San Francisco  
California  
April 10, 1900

RECEIVED  
APRIL 10 1900

San Francisco  
California

San Francisco  
California

San Francisco  
California  
April 10, 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30A REV. 1/68

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07067  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Rebecca Jane Bitteringer			2a. DATE OF DEATH Month Day Year May 20, 1968		2b. HOUR M
3. SEX F	4. RACE White	5. DATE OF BIRTH Jan. 1, 1869		6. AGE (In years last birthday) 99 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Garrett Md.		
10. CITY OR TOWN OF DEATH Grantsville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Goodwill Mennonite Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Garrett	13c. CITY OR TOWN Grantsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last John Burkholder		15. MOTHER'S MAIDEN NAME First Middle Last Mary Spiker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 220-52-9776	17. INFORMANT Address Md. Goodwill Home Records, Grantsville.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC BRAIN SYNDROME</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CIRCULATORY DISTURBANCE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBRAL ARTERIOSCLEROSIS</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. 4379					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 334X					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR <u>9:15</u> Month Day Year <u>9</u> <u>15</u> <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT. 25</u> , 19 <u>65</u> , to <u>MAY 20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>MAY 17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>G. Paige Strong</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>May 20, 1968</u>
22d. PHYSICIAN'S NAME (Type) <u>A. PAIGE STRONG</u>		22e. ADDRESS <u>FROSTBURG, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>5/24/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Robeson Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Avilton, Garrett, Md.</u>	
24. FUNERAL DIRECTOR <u>Luth Newman</u>		ADDRESS <u>Grantsville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 29 1968</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

Chronic Brain Syndrome

Circulatory Disturbance

Cerebral Arteriosclerosis

1 year

x

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May 12 1952

Chronic Brain Syndrome

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First SALEM			Middle AUGUSTUS			Last BROADWATER			2a. DATE OF DEATH May Month 15 Day 1968 Year			2b. HOUR 6:00PM		
3. SEX Male			4. RACE White			5. DATE OF BIRTH July 31, 1880			6. AGE (In years last birthday) 87 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Garrett			Md.					
10. CITY OR TOWN OF DEATH Oakland			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Garrett County Mem.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Garrett			13c. CITY OR TOWN Deer Park			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER					
14. FATHER'S NAME First Henfy			Middle Broadwater			Last Sarah			15. MOTHER'S MAIDEN NAME First Sarah			Middle Olive			Last Duckworth		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no			16b. SOCIAL SECURITY NO. 216-18-1603			17. INFORMANT Mrs. Emma Broadwater, Deer Park, Md.			Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 4120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>years</u> <u>years</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443X <u>Prurient Eczema</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 10, 1968</u> , to <u>MAY 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>15 May 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>A. E. Mance</u>			DEGREE A. E. Mance, M. D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>16 May 68</u>								
22d. PHYSICIAN'S NAME (Type) A. E. Mance, M. D.			22e. ADDRESS Oakland, Maryland														
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE 5/18/68			23c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery			23d. LOCATION (City or Town) (County) (State) Deer Park Garrett Md.								
24. FUNERAL DIRECTOR <u>Gerald N. Minnich</u>			ADDRESS Oakland, Maryland			25a. REC'D BY REGISTRAR DATE <u>MAY 22 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								



22152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR					
Agnes			(None)			DelSignore			Month Day Year May 12, 1968 12:05 PM					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
female		white		Nov. 29, 1896			71 YRS.		MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Italy			USA						Garrett			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Oakland			Garrett Co. Memorial H.			Housewife								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER		
Md.			Garrett						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			On farm		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
First Middle Last			First Middle Last											
Francis			Del Signore			Christine			Wolfe					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No			235-72-2219			Dominick Del Signore			Baywood			Wm.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u>												Sudden		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>												years		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u>												years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
260 X														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <u>March 19 68</u> , to <u>May 12 68</u> , that (I) (we) last saw the deceased alive on <u>March 19 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>A. E. Mance</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>May 15 68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Dr. A. E. Mance</u>						22e. ADDRESS <u>Oakland, Maryland 21550</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			May 15, 1968			Pope Cemetery			Gorman Garrett, Md.					
24. FUNERAL DIRECTOR <u>Thomas, W. Va.</u>						25a. REC'D BY REGISTRAR DATE <u>MAY 15 1968</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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RECEIVED

Nov. 2, 1961

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

07066		07070	
1. DECEASED-NAME (Type or print)		2a. DATE OF DEATH	
First Middle Last Warren Roger DelSignore		Month Day Year May 12, 1968	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)
Male	White	December 2, 1921	46 YRS.
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH
W. Va.	U. S. A.		Garrett Md.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Oakland	Garrett Co. Memorial	Lumber Company Owner	Timber
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
W. Va.	Grant	Gormanla	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last	
Paul Del Signore		Jennie Presutti	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service)		17. INFORMANT Address	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> WW 2		236-20-5724 Frances Del Signore Rt 1 Gormanla, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic heart disease</u> (c) <u>years</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>days</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <u>12 May 1968</u> , to <u>12 May 1968</u> , that (I) (we) last saw the deceased alive on <u>12 May 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>A. E. Mance</u>		22c. DATE SIGNED <u>12 May 68</u>	
22d. PHYSICIAN'S NAME (Type) Dr. A. E. Mance		22e. ADDRESS Oakland, Maryland 21550	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5/15/68	Garrett Co. Mem. Gardens	Oakland, Maryland
24. FUNERAL DIRECTOR <u>Gerald D. Minnich</u>		25a. REC'D BY REGISTRAR <u>MAY 15 1968</u>	
ADDRESS <u>Oakland, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Frances Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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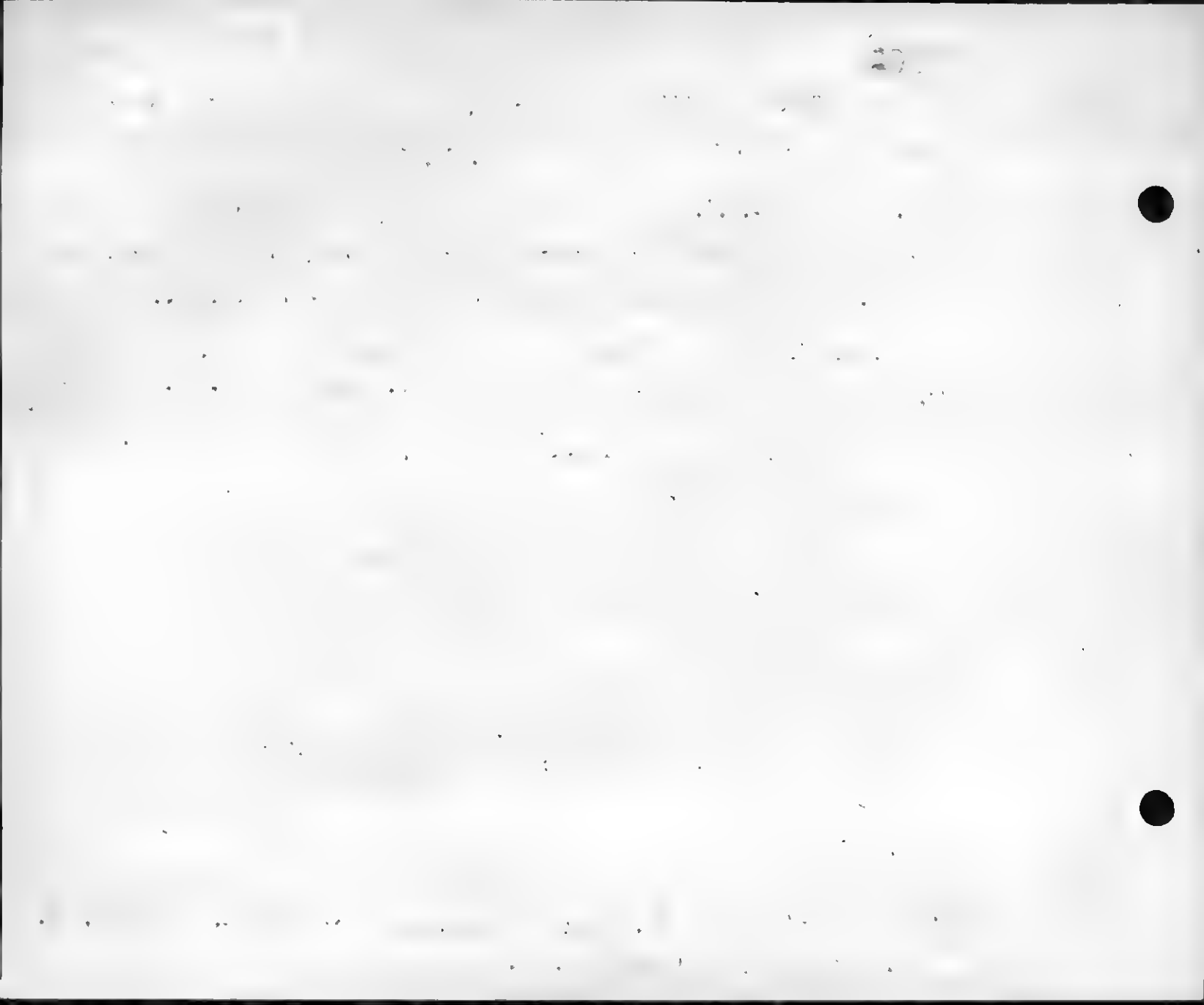
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VR A154  
30M REV 17-68

MD 07068  
MAYARD STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>First ELIZABETH Middle ELLEN Last FLYNN</b>			2a. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1968</b>		2b. HOUR M
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>Feb. 28, 1891</b>	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6 AGE (In years last birthday) <b>77</b> YRS.	
10 CITY OR TOWN OF DEATH <b>Oakland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Oak Rest Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>	
14. FATHER'S NAME <b>First Frederick Middle Adams Last</b>		15 MOTHER'S MAIDEN NAME <b>First Mary Middle E. Last Brode</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>None</b>		17 INFORMANT <b>Michael F. Flynn</b> Address <b>Cumb. Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>22</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7701</b> <b>Emphysema</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Apr. 1966</b> to <b>July 1968</b> , that (I) (we) last saw the deceased alive on <b>5-1-1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Elizabeth Flynn</b>				22c. DATE SIGNED <b>5-15-68</b>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/15/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>	
25a. REC'D BY REGISTRAR <b>MAY 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

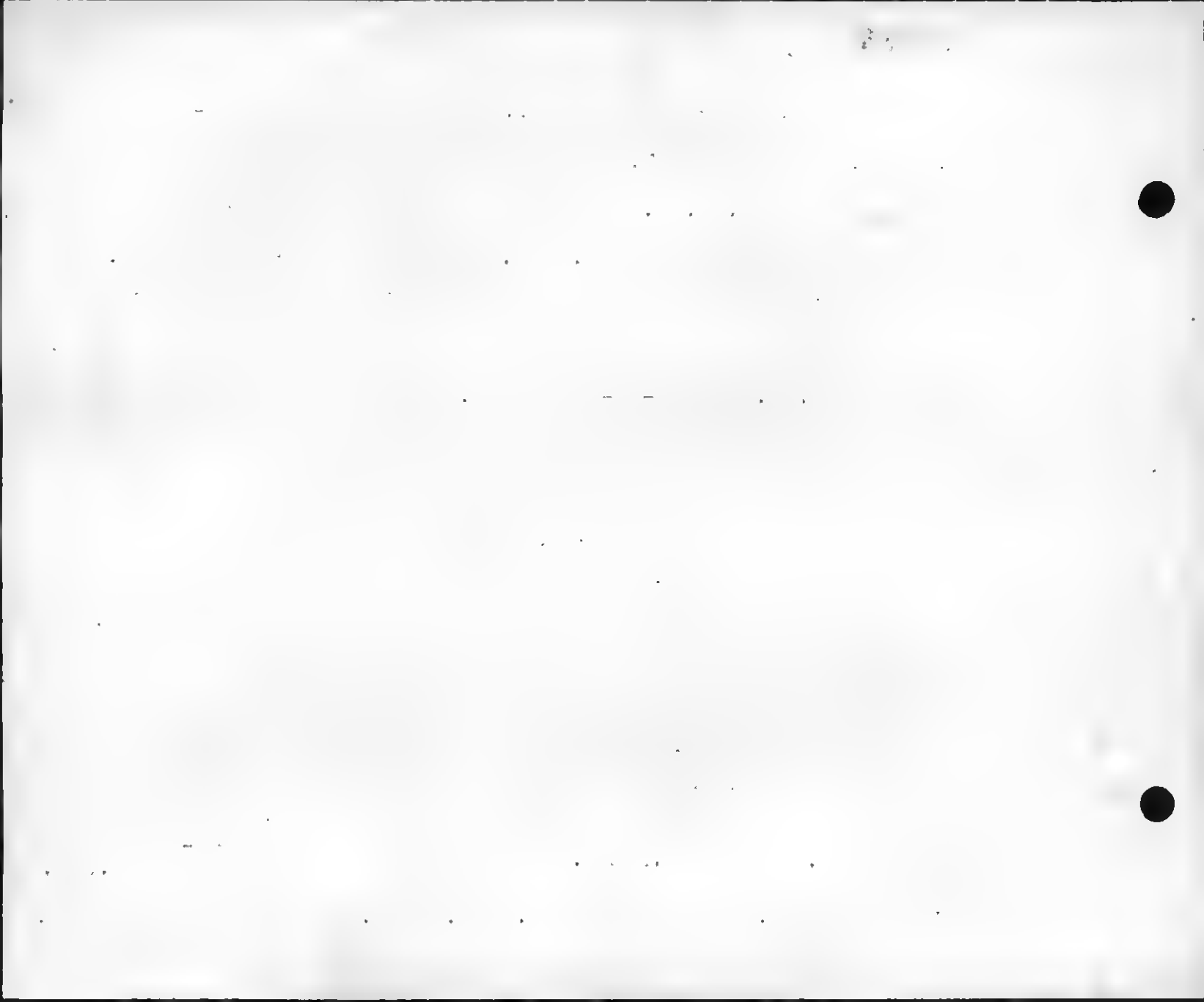
MARYLAND STATE DEPARTMENT OF HEALTH

07066

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <b>Joseph Marcellus Gonder</b>			2a DATE KNOWN OF DEATH Month <b>5</b> Day <b>16</b> Year <b>1968</b>			2b HOUR <b>10:10</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>February 2, 1893</b>	6 AGE (in years last birthday) <b>75</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	2c DATE PRONOUNCED DEAD Month <b>5</b> Day <b>16</b> Year <b>1968</b>		
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Garrett</b>		
10 CITY OR TOWN OF DEATH <b>Oakland</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Garrett Co. Mem.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Mail Carrier</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Post Office</b>		
13a USUAL RESIDENCE (Where deceased lived, if not in hospital residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Garrett</b>		13c CITY OR TOWN <b>Oakland</b>		13d INSIDE CITY - M 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>228 East Alder Street</b>
14 FATHER'S NAME First <b>Frances</b> Middle <b>Gonder</b> Last <b>Gonder</b>			15 MOTHER'S M A D E N NAME First <b>Delia</b> Middle <b>Hines</b> Last <b>Hines</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16b SOCIAL SECURITY NO. <b>W. W. 1 220-44-9485</b>		17 INFORMANT <b>Mrs. Lula Gonder</b>			ADDRESS <b>Oakland, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pulmonary edema, marked</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>  <b>Years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Previous myocardial infarction</b>								
19a. DATE OF OPERATION <b>5-18-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day Year HOUR A.M. <b>19</b> P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2 item 18.)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. <b>228 East Alder Street</b>		City or Town <b>Oakland</b>		County <b>Garrett</b> State <b>Md.</b>
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M. D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <b>5-16-68</b>		
EXAMINER'S NAME (Type)				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
				ADDRESS (Street, city, town, or county) <b>Oakland, Garr., Md.</b>				
23a BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b DATE <b>5/18/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Garrett Co. Mem. Gard</b>		23d LOCATION (City or Town) (County) (State) <b>Oakland Garrett Md.</b>		
24a FUNERAL DIRECTOR <b>Gerald N. Minnich</b>				ADDRESS <b>Oakland, Maryland</b>		25a RECD BY REGISTRAR <b>MAY 22 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 475  
304 REV. 7-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Robert Grover Lee						May 9, 1968			1:00 AM	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	White	6-8-88		79 YRS.		MONTHS DAYS		HOURS MIN		
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Oakland, Md.	America USA			Garrett Md						
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
Oakland	Garrett Co. Mem. Hospital		Farmer		Gen. Farming					
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER						
Md.	Garrett	Oakland	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Rt. 2 Box 305						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
George David Lee			Lydia Susan Gower							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17. INFORMANT		Address				
No		213-12-9212		Mrs. R. Grover Lee, (Widow)		Route 2, Oakland, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonia, Bronchitis, Bilateral</u> 3 days										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure Pulmonary Edema 1 year</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease Unknown</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>425</u>										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION		Street or R.F.D. No.		City or Town		State
22a I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>68</u> , to <u>May 9</u> , 19 <u>68</u> , that (I) ( <del>we</del> ) lost saw the deceased alive on <u>May 9</u> , 19 <u>68</u> , and that (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>do not</del> ) view the body after death.										
22b SIGNATURE						22c DATE SIGNED				
<u>Dr. H. Leighton</u>						9 May 68				
22d PHYSICIAN'S NAME (Type)		22e ADDRESS								
Dr. H. Leighton		Oakland, Maryland 21550								
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		5/12/68		Eglen Cemetery		Eglen, Preston, W. Va.				
24 FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
John O. Burst, Oakland, Maryland				MAY 13 1968		Charles Judge				



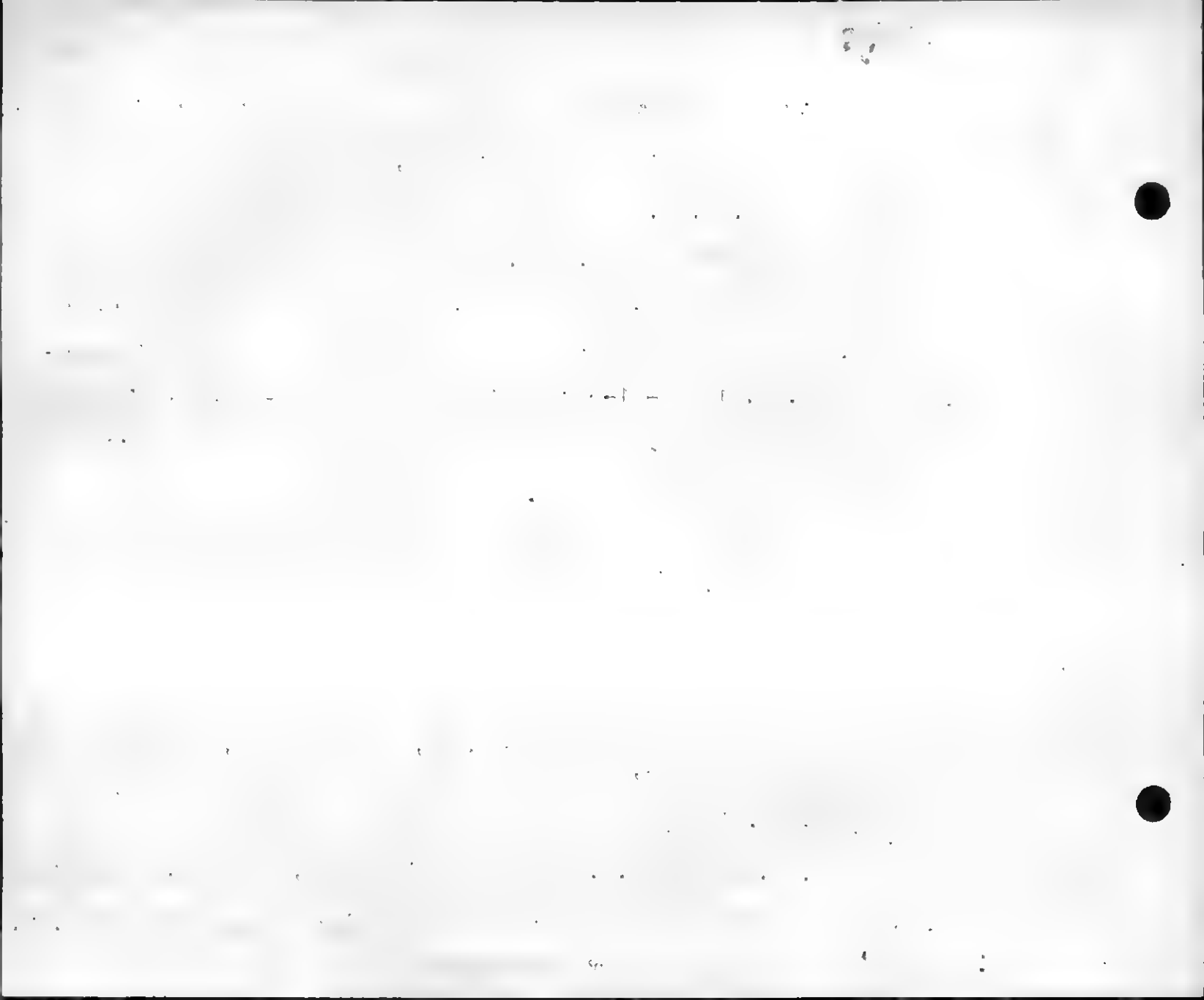
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VR A15(4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) First <b>Harry</b> Middle <b>Sherman</b> Last <b>Lewis</b>			2a. DATE OF DEATH Month <b>May</b> Day <b>14</b> Year <b>1968</b>		2b. HOUR <b>11:10 AM</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>July 27, 1891</b>		6 AGE (In years last birthday) <b>76</b> YRS	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Garrett</b> Md.					
10 CITY OR TOWN OF DEATH <b>Oakland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Garrett Co. Mem.</b>		12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Mechanic</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>					
13a. U.S.A. RESIDENCE (Where deceased lived, if not in residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Garrett</b>		13c. CITY OR TOWN <b>Loch Lynn</b>	
13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>404 Seneca Ave.</b>			
14. FATHER'S NAME First <b>Phillip</b> Middle <b></b> Last <b>Lewis</b>			15. MOTHER'S MAIDEN NAME First <b>Cora</b> Middle <b></b> Last <b>Whitehair</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>yes</b>		16b. SOCIAL SECURITY NO <b>213-01-5667</b>		17. INFORMANT <b>Porter Lewis</b> Address <b>Crellin, Maryland</b>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction.</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis generalized.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Uremia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>APR. 23, 1968</b> to <b>MAY 14, 1968</b> , that (I) (we) last saw the deceased alive on <b>MAY 14, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>B. L. Grant</b>				22c. DATE SIGNED <b>5-15-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>B. L. Grant, M.D.</b>				22e. ADDRESS <b>Second Street, Oakland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>5/17/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Terra Alta Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Terra Alta Preston W. Va.</b>					
24. FUNERAL DIRECTOR <b>Gerald M. Minnich</b>		ADDRESS <b>Oakland, Maryland</b>		25a. REC'D BY REGISTRAR <b>MAY 22 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

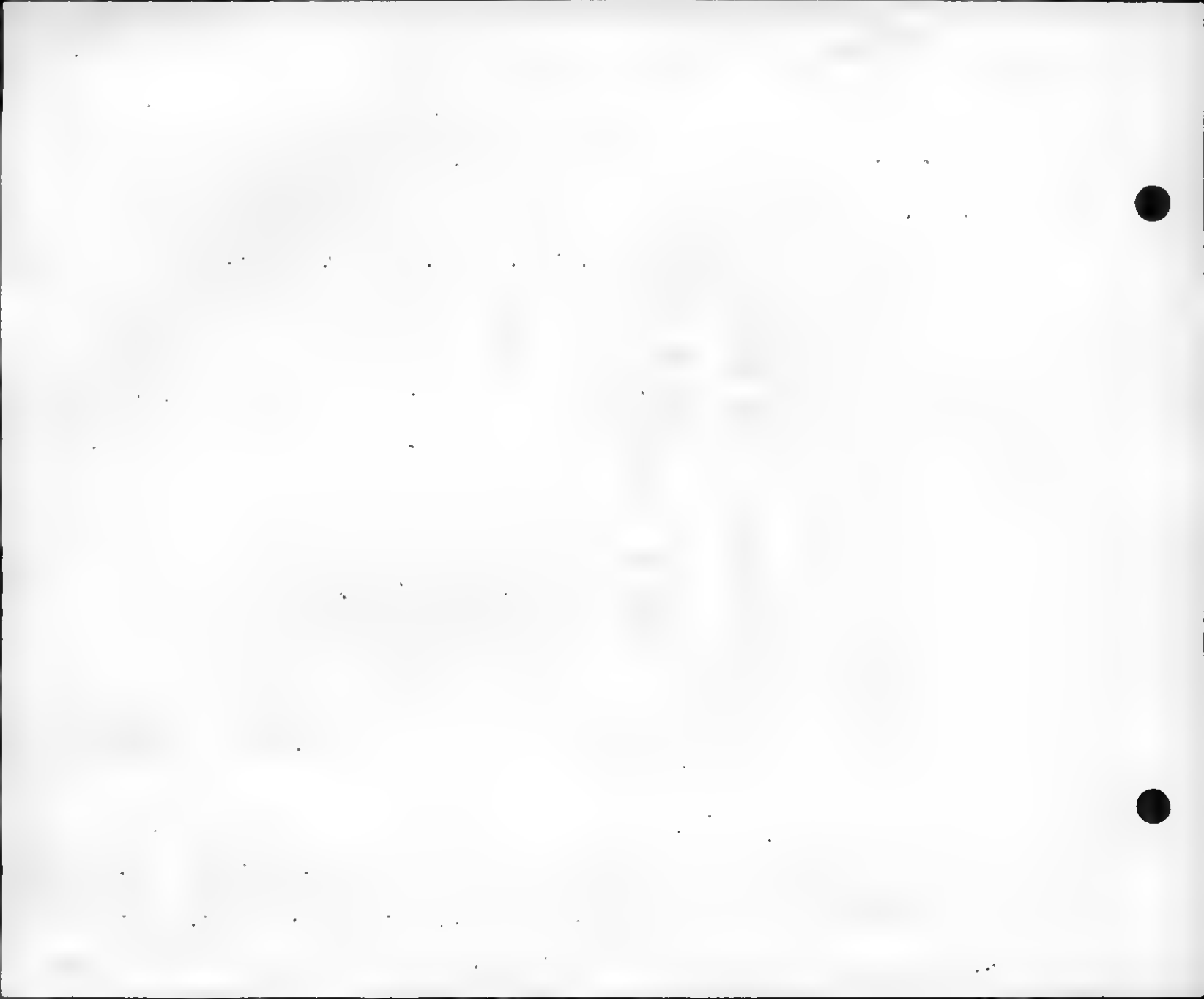










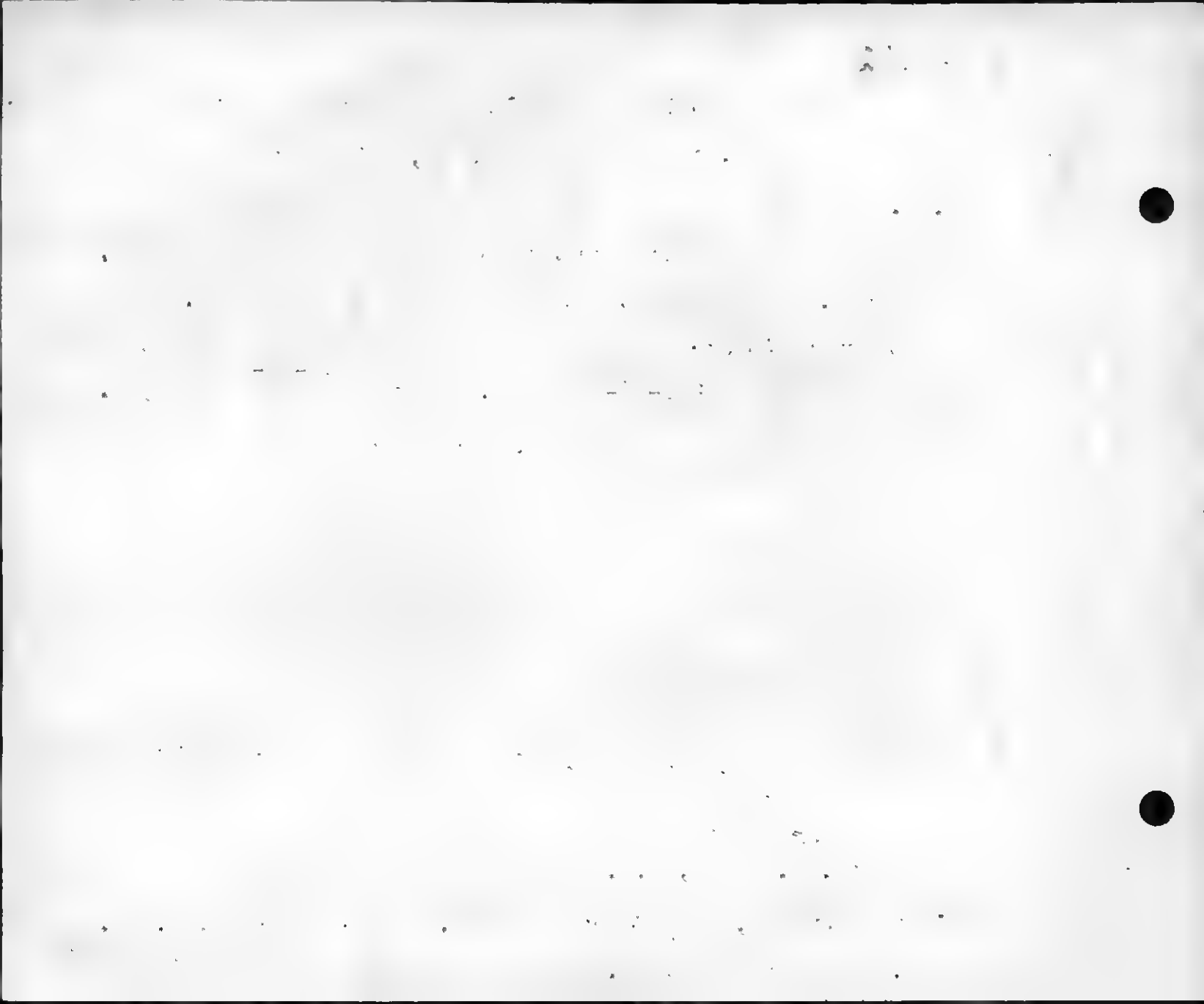


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <b>ALVA ROSS MARTIN</b>		2a DATE OF DEATH <b>May 31 1968</b>		2b HOUR <b>12 Noon</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>June 19, 1889</b>	
7a BIRTHPLACE (State or foreign country) <b>W. Va.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		6 AGE (in years at birthday) <b>78</b> YRS	
10 CITY OR TOWN OF DEATH <b>Oakland</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Oakrest Nursing Home</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Farmer</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b COUNTY <b>Garrett</b>		13c CITY OR TOWN <b>Oakland</b>	
14 FATHER'S NAME First <b>Chauncy</b> Middle <b>Jerome</b> Last <b>Martin</b>		15 MOTHER'S MAIDEN NAME First <b>Rebecca Virginia</b> Middle <b>DeWitt</b> Last <b></b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>No</b>		16b SOCIAL SECURITY NO <b>234-26-0523</b>		17 INFORMANT <b>(Sister-in-Law) Mrs. Robert Martin, Oakland, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> X DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>2 yrs</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State	
22a I certify that (I) (this hospital) attended the deceased from <b>Feb</b> , 19 <b>63</b> , to <b>May</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>May 31</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>B. L. Grant, M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c DATE SIGNED
22d PHYSICIAN'S NAME (Type) <b>B. L. Grant, M.D.</b>					22e ADDRESS <b>Oakland, Maryland</b>
23a BURIAL, CREMATION, REMOVA (Specify)		23b DATE <b>June 2, 1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Terra Alta Cem.</b>	
23d LOCATION (City or Town) <b>Terra Alta, W. Va.</b>		(County)		(State)	
24 FUNERAL DIRECTOR <b>John O. Durst</b>		ADDRESS <b>Oakland, Md.</b>		25a REC'D BY REGISTRAR <b>JUN 4 1968</b>	
				25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



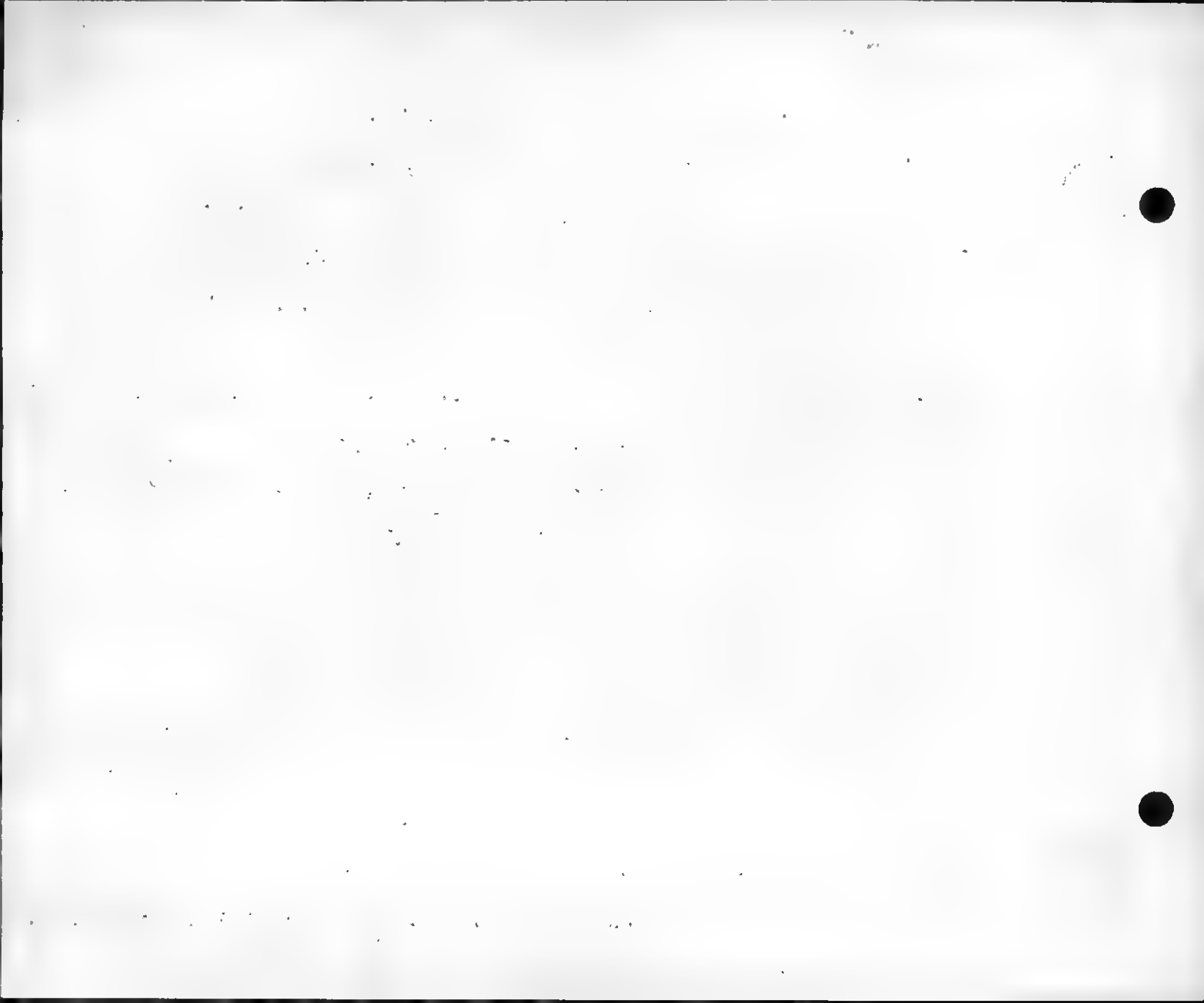
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-66

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <b>MATTHEW ELLIS MARTIN, Sr.</b>			2a. DATE OF DEATH Month Day Year <b>MAY 9 1968</b>			2b. HOUR <b>8:50 AM</b>			
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>JUNE 21, 1890</b>		6 AGE (In years last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>GARRETT Md</b>			
10 CITY OR TOWN OF DEATH <b>OAKLAND</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>GARRETT COUNTY MEMORIAL</b>		12a. USJA. OCCUPATION (Kind of work done during most of work age, even if retired) <b>SUPERINTENDENT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FORESTRY</b>			
13a. USJA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>GARRETT</b>		13c. CITY OR TOWN <b>GRANTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>P.O. - BOX # 123</b>	
14. FATHER'S NAME First Middle Last <b>MATTHEW MARTIN</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>REBECCA HILL</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT (WIFE) <b>LULA C. MARTIN</b>		Address <b>GRANTSVILLE, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarct due to a fatty soap</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>8 May, 1968</u> to <u>9 May, 1968</u> , that (I) (we) last saw the deceased alive on <u>9 May, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Andrew E. Mance</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>9 May 68</u>			
22d. PHYSICIAN'S NAME (Type) <b>ANDREW E. MANCE, M.D.</b>				22e. ADDRESS <b>THIRD STREET OAKLAND, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5/12/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grantsville Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Grantsville, Garrett, Md.</b>			
24. FUNERAL DIRECTOR <u>Luth Flewmen</u>				ADDRESS <b>Grantsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 15 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



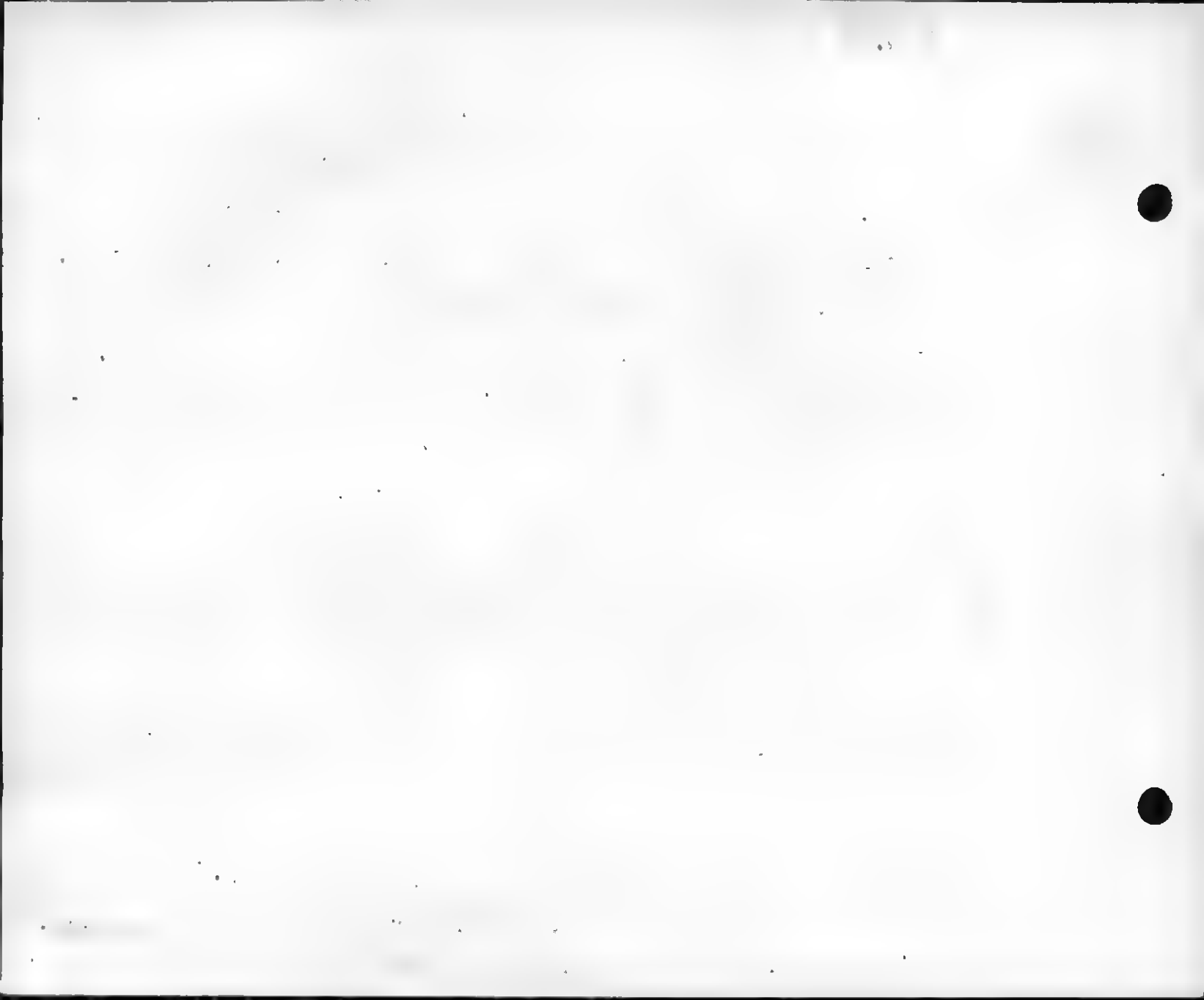


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last Genevieve Ruth Miller						2a. DATE OF DEATH Month Day Year May 27, 1968			2b. HOUR 6:30 PM		
3 SEX F		4. RACE White		5. DATE OF BIRTH July 23, 1913		6 AGE (In years last birthday) 54 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTH-PLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Garrett Md.					
10. CITY OR TOWN OF DEATH Grantsville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Selling Undergarment Co.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.			13b. COUNTY Garrett		13c. CITY OR TOWN Grantsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last Milton Bailey				15. MOTHER'S MAIDEN NAME First Middle Last Effie Warnick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO		17 INFORMANT Address Christian Miller, Grantsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) metastatic carcinoma 1511 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Pancreas 4 months DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 157											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 4/26, 1963, to 5-26, 1968, that (I) (we) last saw the deceased alive on 5-26, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Grant Titmuss M.D. DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5-27-68			
22d. PHYSICIAN'S NAME (Type) Grant Titmuss						22e. ADDRESS Newersdale, Pa.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 5/29/68		23c. NAME OF CEMETERY OR CREMATORY Grantsville Cemetery		23d. LOCATION (City or Town) (County) (State) Grantsville, Garrett, Md.					
24. FUNERAL DIRECTOR Ruth Newman						25a. REC'D BY REGISTRAR DATE MAY 29 1968		25b. REGISTRAR'S SIGNATURE			



# FOR STATE HEALTH DEPT.

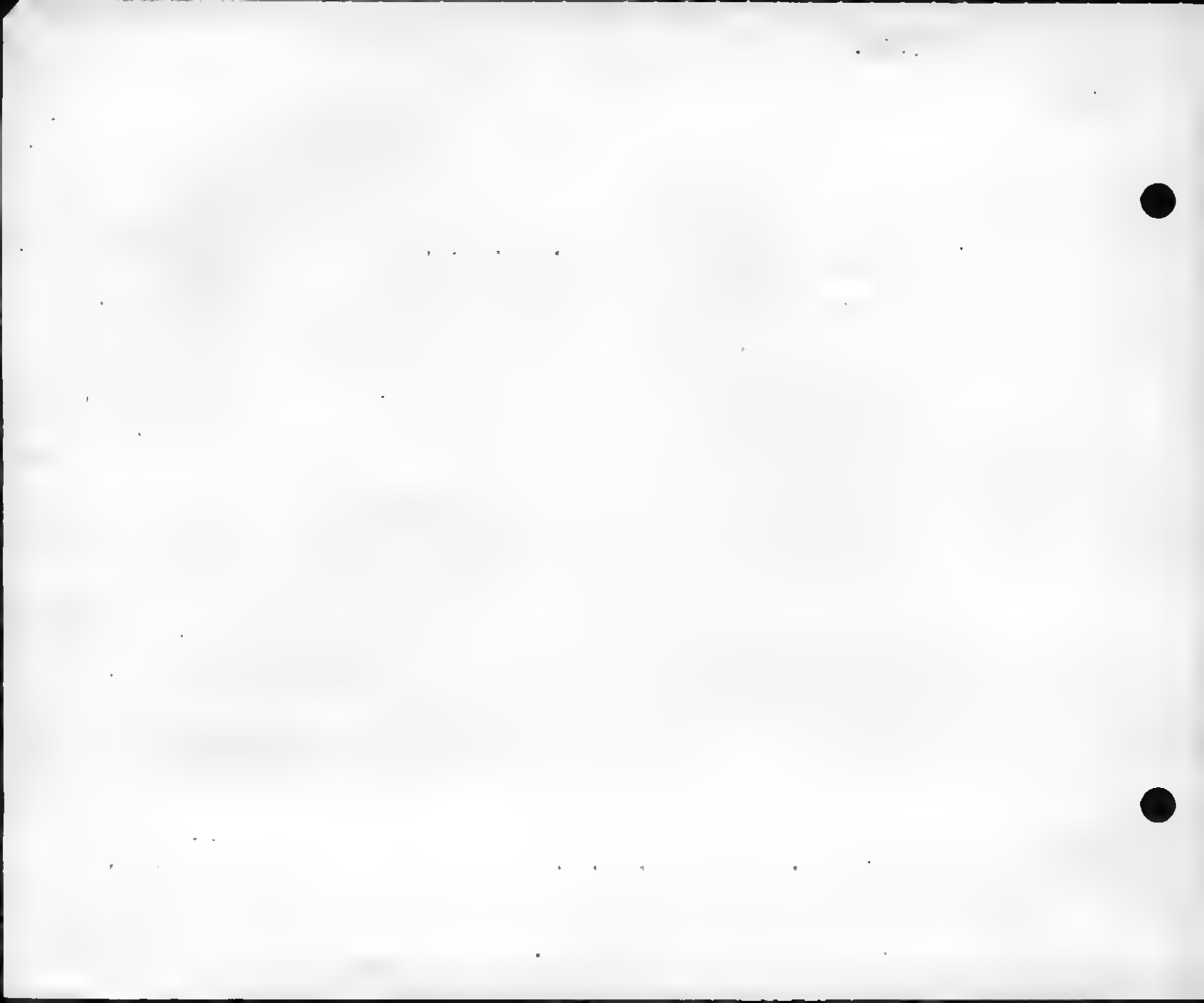
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form IM-3 (Page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

87074

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
Jesse		H.		Shadwell				2c DATE PRONOUNCED DEAD		Month	Day	Year	2d HOUR
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE, in years (last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.		7c DATE PRONOUNCED DEAD		Month	Day	Year	2d HOUR
Male	White	July 15, 1923		44 YRS				Month 5		Day 6	Year 1968	1:10 P.M.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH							
Cumberland		USA				Garrett							
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY							
Oakland		(DCA) Garrett Co. Mem. Hosp.		Dentist & Roofer		Contracting							
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, L.A. 15?		13e STREET AND NUMBER					
Md.		Allegheny		Cumberland		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		30 West First St.					
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First		Middle	
Charles H. Shadwell								Dephia Bean					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOC. A. SECURITY NO.		17 INFORMANT		ADDRESS							
yes		War II		Mrs. Verna Lee Shadwell, Cumberland, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CORONARY SCLEROSIS WITH THROMBOSIS (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN --													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) f x u i													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)									
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		James H. Feaster, Jr., M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5-6-68	
						ADDRESS (Street, city, town, or county)		Oakland, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)			
Burial		May 9, 1968		Greenmount Cemetery		Cumberland, Allegheny, Md.							
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE							
James F. Scarselli, Cumberland, Md.				DATE MAY 8 1968		Charles Judge							



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07075

07081

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Garrett</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kitzmiller</b> <span style="float: right;">c. LENGTH OF STAY IN TB <b>53yrs.</b></span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Main Street</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Garrett</b></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kitzmiller</b> d. STREET ADDRESS <b>Center Street</b> <span style="float: right;">e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></span>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Mildred Naomi Sharpless</b>		<b>4. DATE OF DEATH</b> Month <b>May</b> Day <b>20</b> Year <b>1968</b>		<b>5. SEX</b> <b>Female</b> <span style="float: right;">6. COLOR OR RACE <b>White</b></span> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <span style="float: right;">8. DATE OF BIRTH <b>Dec. 10, 1914</b></span> <b>WIDOWED</b> <input checked="" type="checkbox"/> <span style="float: right;">9. AGE (in years last birthday) <b>53</b></span> <b>DIVORCED</b> <input type="checkbox"/> <span style="float: right;">IF UNDER 1 YEAR Months Days</span> <span style="float: right;">IF UNDER 24 HRS. Hours Min.</span>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Kitzmiller, Md.</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>Robert Thomas Davis</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Bertha Ellen Simon</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>215-26-9431</b>		<b>17. INFORMANT</b> <b>Mrs. Goldie Green, Kitzmiller, Md.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO (b) <b>Coronary artery disease</b> (c) <b>Coronary atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>170x</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> D.M.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>June 19, 1967</b> <b>to</b> <b>May 20, 1968</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>May 20, 1968</b> , <b>and that death occurred at</b> <b>3:25p</b> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <b>Dr. Ralph Calandrella</b> <span style="float: right;">M.D.</span>				<b>22b. DATE SIGNED</b> <b>May 20, 1968</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. Ralph Calandrella</b>				<b>22d. ADDRESS</b> <b>Kitzmiller, Md. 21538</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>May 23, 1968</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Nethken Hill Cemetery</b>			
<b>23d. LOCATION (City, town or county)</b> <b>Elk Garden, Mineral Co. W.Va.</b>		<b>23e. (State)</b>		<b>23f. (Country)</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Amey Mildred Sharpless</b> <span style="float: right;">P.O. Kitzmiller, Md.</span>							
<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07072



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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**CERTIFICATE OF DEATH**

07076

07082

1. DECEASED NAME (Type or print) <b>Claude William Simmons</b>			2a. DATE OF DEATH Month <b>May</b> Day <b>3</b> Year <b>1968</b>		2b. HOUR <b>4:25</b> PM
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>April 29, 1906</b>		6. AGE (In years last birthday) <b>61</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Garrett</b> Md.
10. CITY OR TOWN OF DEATH <b>Oakland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Garrett Co. Memorial Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Miner</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>W. Va.</b>		13b. COUNTY <b>Grant</b>	13c. CITY OR TOWN <b>Gorman</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Route # 1 Box # 91</b>
14. FATHER'S NAME First <b>Adam</b> Middle <b>Simmons</b> Last <b>Simmons</b>			15. MOTHER'S MAIDEN NAME First <b>Suzanne</b> Middle <b>Wolf</b> Last <b>Wolf</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>236-11-6859</b>		17. INFORMANT <b>Wilton Carr</b> Address <b>Baltimore, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>443x</b> (b) <b>Hypertensive Arteriosclerotic Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b> Years _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>Anemia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. _____ P.M. _____ 19 _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept.</b> , 19 <b>64</b> , to <b>May 3</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>B. L. Grant</i>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>Dr. B. L. Grant</b>				22e. ADDRESS <b>Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>5-6-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	
23d. LOCATION (City or Town) <b>Garrett Co.</b>		(County) <b>Md.</b>		(State)	
24. FUNERAL DIRECTOR <b>Herald D. Minnich</b>		ADDRESS <b>Oakland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 9 1968</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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